



INFORMATION REQUEST

Date:			
Patient:		Patient ID:	
DOB:			

The following information is requested from your medical records of the above individual. Please fax the following documentation to 716-839-3338.

	Laboratory test BUN and Creatinine Results
	Previous MRI and CT Reports
	Doppler Reports
	Ultrasound Reports
	Operative Reports on:
	Implant/Explant Report (Make, Model and Serial Number):
	Other:

This is to be used for payment and treatment purposes only. Should you have any questions, please contact us at 716-839-3333.

Thank you for your cooperation.

Sincerely,

Hari Gopal, M.D.
Ronald Femia, M.D.
Medical Directors
Buffalo Diagnostic Imaging, PLLC